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ORIGINAL ARTICLES.

Gonorrhœal Ophthalmia.

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The word gonorrhœa means to flow, and denotes an involuntary discharge of semen, but it is commonly applied to an infectious pus-like discharge from the genitals. Neisser found a micro-organism in gonorrhœal pus in 1879, and called it micrococcus gonorrhœa. These observations have been confirmed by a large number of observers.

Other investigators find the same organism in pus from acute abscess and in normal human saliva, and do not believe the gonococcus to be distinguished from other micro-organisms.

Urethritis has been produced by injections of ammonia, and the same identical microbe found as those found in cases with a clear history of contagion.

The microbe is a diplococcus, and usually found in clumps, but, as before stated, it cannot be differentiated from the pseudo-gonococcus. Gonorrhœa is an acute, contagious, infectious specific disease, and is self-limited. It is a local and constitutional disease.

The cause of the pathological change in the tissues is said to be due to the ptomaine and not to the presence of the living micro-organism.

The etymology of the word ptomaine is "a corpse," hence it would be inferred that all microbic diseases are caused by the putrefaction of dead microbes and cells.

These bodies putrefy and form a new compound.

The ptomaines are of vegetable and animal origin. Some are poisonous, but a great number are not, and all toxic products of putrefaction are not ptomaines. It is generally believed that all putrefaction is due to micro-organisms and the kinds of ptomaine being due to a peculiar bacterium or combination of them, and also dependent upon the stage of putrefaction, as they are transition products in the process of putrefaction. To summarize:

1. The probability is that gonococci are always present in the human body or its secretions.

2. These microbes are nature's standing army, ready and at work at all times in silently expelling the foe; but when the invasion is very great, the product is not eliminated as fast as formed, and marked local or constitutional disturbances result.

3. In the fight they lose their lives, and their death is nature's first preliminary step toward the elimination of the specific virus.

4. The second step is a putrefactive change and the splitting up of the chemical constituents of the dead micro-organisms and tissue cells, and the formation of new chemical compounds which are called ptomaines.

There are two classes of micro-organisms—the infective and non-infective. Respecting the last statement, it is probable that there is but the one principle *per se*, and the various forms or shapes assumed by the microbes are due to the stage of putrefaction.

In all organized bodies the changes occurring in them by which they revert into original inanimate matter is called disease. *Ease* meaning a state of rest and *dis* meaning the negative or a change. In animal or vegetable life it is the same, and the gist of the whole subject of disease may be

summed up in chemical and chemico-vital changes, and the various organisms found in the body are the natural agents provided for the purpose of quickly returning organized matter back into its original elements.

The virus is usually conveyed to the eye from the genital organs by the hand or from wiping on clothes containing the poison, and in infants in their passage through the maternal canal.

The symptoms develop in the following order usually: Itching, pricking or burning sensation in the eye, followed by redness with congestion of the mucous membrane more or less diffuse. The secretion is increased and soon becomes floculent, containing flakes of mucus, then mucopurulent, and, finally, purulent. The eyelids swell and the ocular conjunctiva becomes chemotic. The secretions are icherous and the swelling causes pressure, thus cutting off the blood supply, and the pain becomes great at times. There is often an elevation of temperature with anorexia and constipation. Loss of appetite is attributed to the pain by the patient. There is more or less depression of spirits, due in part to the physical condition of the patient, but if the patient knows that the eye trouble is gonorrhœal, the depression is generally greater.

Prophylaxis is of the first consideration. In lying-in hospitals, where the blindness from this cause was great in former years, it has been reduced to a minimum at the present. The child is thoroughly cleansed and a solution of nitrate of silver, from one-half to two per cent., is dropped into the eyes. Patients suffering from gonorrhœa or gleet should be forcibly reminded that by carelessness in not washing their hands every time they are exposed they may convey the poison to others, and get it in their own eyes and destroy them. The clothes used should be burned, and the most scrupulous care enjoyed.

TREATMENT.

In the beginning of the ophthalmia a boracic acid wash should be used freely as follows:

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Acidi borici (crystals).....℥ ij

Sig.: To be used as follows:

1. Divide the salt into eight equal parts.

2. Put one part into one quart of soft boiled water, cork and keep in a cool place.

3. Bathe the eye every hour or two with a few tablespoonfuls of the medicated water as hot as can be endured, letting the fluid get into the affected eye freely. The object is to keep the eye clean, to dilute and thin the poisonous excretions,* and in this way assist nature to eliminate the irritant. In from four to six hours the patient should be seen again, and if the eye is painful or the swelling of the lids increases, or the excretions be more copious, a solution of nitrate of silver (one grain to the ounce of distilled water) should be dropped into the eye and the boric acid wash continued as before directed, and the patient seen in a few hours again. Should the symptoms increase on the next visit, the lids and conjunctiva be more swollen, the muco-purulent discharge be free, or if the case is not seen until this stage is present, the eye should be irrigated and a two-per-cent. solution of the nitrate of silver dropped in the eye. The patient can irrigate the eye himself. All that is necessary is three or four feet of rubber tubing, about ⅛ of an inch, and a vessel containing the boiled water, cooled to endurance by letting it stand or putting the vessel in cold water; but cold water should not be added, as that would destroy the effect of the boiling. The water can be syphoned onto and in the eye. The silver should be applied every twelve to twenty-four hours, according to the indication. A softening or slight wrinkling of the lid and a lessening of the excretions and pain, any and all are favorable indications. For an hour or two after the application of the silver the excretions are apt to be more copious and stringy. These strings of mucus *must* be kept *out* of the *eye*.

Where the chemosis is excessive the conjunctiva should be slit in various directions to relieve the pressure on the globe of the eye, and if this does not give relief, a canthotomy must be done; and should the pressure yet remain too great, the upper lid

*Used in the sense of a foreign body.

should be cut into from the center of its margin to the brow. In this way the pressure is taken off the eye and the whole mucous surface is exposed, and the parts can be kept clean. The edges of the cut lid must be freshened and sutured when the inflammation subsides. When the inflammation becomes so great the pupil should be kept dilated. Atropine often increases the tension of the globe, and in this way increases the pain, but it is necessary to use it to prevent synechia; and an occasional dilatation of the pupil at least once every second day should be done. If it causes pain, eserine should be used between times, from one-half to one grain to the ounce of distilled water, and one drop of this solution dropped into the eye every hour until myosis is secured, then wait a day.

The excessive swelling of the lids and of the conjunctiva produces pressure on the bloodvessels of the eye, cutting off nutrition from the cornea and in this way causing it to break down. With this destruction of the cornea, perforation follows, with hernia of the iris and often total destruction of the eye. If the hernia is central and recent, it should be returned, and a four-grain solution of atropine used to draw the iris away from the ulcer; but if the iris is necrosed or it is of long standing, it should be snipped off and the mydriatic used. If the ulcer is marginal, eserine should be employed. When the sight of the eye is destroyed and there is marked sympathetic trouble in the other eye, the diseased eye should be removed. In infants and children removal of an eye interferes with the development of that side of the face, and is an objection to removal of an eye in those cases.

We desire to emphasize the necessity of cleanliness, and the eye must be kept clean if it has to be washed every fifteen minutes. Occasionally cold applications are best tolerated and give better results, but as a rule the hot applications meet the indications best. Patients in these eye troubles generally tolerate the mydriatic well, but they should always be told when the fauces become excessively dry or a red rash appears on the skin less of the drug must be used.

The patient should have plenty of soft clothes or clean cotton to wipe on, and the eyelids should not be rubbed, but gently pressed on like sponging. These clothes or cotton pellets should be burned immediately. The lids and eye should be smeared occasionally with vaseline or vaseline with one-half grain of cocaine to the ounce to keep them from sticking together and for the soothing effect, and to prevent excoriation of the skin by the excretions.

Constitutional treatment is generally required before the eye gets well. There should be a free evacuation of the bowels once a day in the beginning of the attack and while the appetite remains good. If they are sluggish they should be moved by a dose of sulphate of magnesia or seidlitz powder, and from one-fourth to one grain of calomel given, well triturated in sugar of milk, three times a day or frequent enough to keep them regular and at the same time not to debilitate the patient. Should the appetite fail, or if there is some fever or there be much depression of spirits, from two to three grains of quinine should be given three times a day just after meals. A good bath should be taken twice a week, the nurse doing the rubbing. The surrounding should be made as cheerful as possible, for there is usually great depression of the mind. The room must be well ventilated, the walls as free as possible from hangings, the floor bare, except here and there a rug may be allowed, and mopped every day, and as much light permitted to enter the room as the patient can endure with comfort.

The patient should have a nourishing, easily-digestible diet, but not the fat-forming foods, the latter at least to a limited extent. Quiet should be enjoined, and stimulants and narcotics prohibited in the main.

The source of the infection must be removed, for one attack does not exempt from another.

Authority consulted, Gould's Dictionary.

IT is suggested that the crowded condition of the medical profession is due to the "misfits" in it.

Report of a Few Cases of Abdominal and Pelvic Surgery.

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It is a thorough understanding of the unexpected in intra-peritoneal surgery that makes the abdominal surgeon's work a special class of work, and this familiarity with the "unlooked for" is gained only by a study of the reports of many cases by various writers, to which is added a more or less personal experience at the operating table. Each abdominal surgical case, it is true, is an individual one, yet in all the characters are such as to admit of a general classification, both in the pathology and the surgery.

CASE I. *Œdematous Myoma, Hysterectomy. —Recovery.*

This lady (aged forty, single) for six months prior to my first visit to her, had noticed an enlargement in the lower abdomen, centrally located, free from pain or other unpleasant symptoms. Her menstrual periods have always been regular in time and duration, normal in quantity and quality. At the time I saw her first she presented the appearance of a woman six months' pregnant, fairly well nourished and in moderately good health. She had for two or three months kept herself in retirement lest some unjust accusations be made; her character was one above suspicion.

On examining her, I found a smoothe globular enlargement centrally located, painless, movable, semi-fluctuating.

Digital examination revealed a softened cervix with a patulous os; on introducing a finger into which, a bulging, resembling slightly in its contour a fœtal head, could be felt; no fœtal heart sounds, but at lower part of the growth on the right side could be heard a bruit which was very much like a placental sound. The elimination of a pregnancy was the first thing to be done in arriving at a prognosis. The high social and moral standing of any patient should not deter the gynecologist from carrying his investigations in all directions. The irreproachable character of the lady was an important eliminative factor, but not alone of sufficient import to exclude pregnancy. She was menstruating regularly; fœtal heart sounds were absent (an important diagnostic symptom when present).

The placental soufle is a diagnostic symptom of much value when present, but we must recall the fact that in uterine fibroids and myomatous growths we frequently have a bruit. This symptom can only be taken as evidence when its presence is attended with other diagnostic manifestations of pregnancy. The absence of fœtal heart sounds and movements, morning sickness, regular menstruation, no change in the breast, no nausea and the peculiar feel of the growth warranted me in diagnosing a myomatous growth. The growth being a rapid one in its development, and one not checked by the menopause, an operation was recommended and consent obtained. I performed an abdominal hysterectomy, fixing a small pedicle in the lower angle of the abdominal incision by the aid of pins and Koebele soerre noeud.

The growth was as I had diagnosed — an œdematous myoma, weighing twenty-two pounds. Her recovery in every respect was perfect, and at this time (eight months after operation) is enjoying the best of good health.

The growth, when delivered through the abdominal incision, presented a pedicle six inches in diameter, but by "stripping" the capsule and dropping it the pedicle was reduced, after raising the tumor, to the size of an infant's wrist.

Many operators who try to perform this operation fail because they do not understand the technique of the method in making a small pedicle.

CASE II. Married, age thirty; no children. Husband had gonorrhœa just before marriage. Says she has on many occasions had a profuse purulent discharge. Has complained of pains in pelvis for ten years. Was married ten years ago. Suffers much

at menstrual periods. Sexual intercourse painful (dysparemia). Riding over rough roads gives much pain in pelvis. Has had several attacks of what was termed "inflammation of the bowels," these attacks putting her in bed from one to three weeks. Examination reveals the pelvis full of inflammatory bands, matting together omentum, bowels, uterus, bladder, ureters, Fallopian tubes and uterus.

Her purulent discharges were evidently of gonorrhœal origin, the disease extending to the uterus and tubes, had produced a closure of the uterine and abdominal tubal ostæ, resulting in a sterility.

The attacks of "inflammation of the bowels" were relapsing or recurring attacks of pelvic peritonitis, due to a leakage from the diseased pus-ladened tubes. These attacks with each recurrence lead to additional inflammatory bands (adhesions), matting the pelvic organs together, destroying their physiological function and leaving worse than useless organs to encroach upon and cripple surrounding organs, essential to life and comfortable existence.

The operation revealed a state of affairs to be found in the majority of these old and neglected pus cases. It required much care to remove the diseased structures and to liberate sound imprisoned organs. A large ovarian abscess ruptured unavoidably, spilling its contents into the pelvis. A thorough irrigation with hot sterilized water and a drainage tube made her recovery one of an uninterrupted character. Her cheeks to-day are rosy, she is free from pain, and is in an ideal physical and mental condition in as far as concerns comfort and contentment.

She had been "treated" for years; she had been curetted, packed, etc., etc., and with the result of always making her worse. Some writers would have us believe these cases can be cured by curetting and drainage with a catheter in the Fallopian tube, etc., etc. It would be impossible for anyone to empty a Fallopian tube in this condition with a catheter, even though the specimen be held in the hand and the effort made under the guidance of the eye. Some writers call this class of surgery "mutilating," and these same gentlemen continue practicing gynecology (?) for "revenue only" by having an office filled each day with suffering women, who are carrying pus-filled tubes and ovarian abscesses, waiting their turns to have their vaginal vaults painted with Churchill's tincture or other equally inefficient (in these cases) applications.

CASE III. *Appendicitis, Perforation, Operation, Recovery.*

Female, aged twenty-three. Previous health good. Healthy looking, robust German girl. Was taken with acute pain in the region of the appendix three days before I saw her.

On the morning of the third day of her illness this pain became more severe with the development of symptoms of collapse. She has had tenderness from the first day over the location of appendix; has had a little fever each afternoon; 101° F., pulse 116, constipated. At the time I saw her she had a subnormal temperature with a pulse of 120, sweating profusely, vomiting, distended abdomen. Two hours before I saw her she was taken with very acute pain in region of the appendix, which I interpreted as due to a perforation of the appendix; following this, immediately a pronounced collapse set in. An operation was advised and performed at once. Giving the patient a hypodermic of one-thirtieth strychnia before beginning the ether, knowing the necessity for rapid surgery and the danger from prolonged anæsthesia in a patient in this state, everything was made ready (as I always do) that no delays be caused by incomplete preparation of instruments and dressings. Operation lasted only sixteen minutes. Incision over the appendix, which was found with a perforation at its base with an orange seed still in the opening. Appendix removed and surroundings washed with sterilized water and peroxide of hydrogen; a good-sized piece of iodoform gauze left in the incision down to base of cæcum as a drainage. This early and quick surgery saved the life of this pa-

tient, yet a three days' delay came near being too long.

Cases of appendicitis with the usual operative indications should be operated on as soon as diagnosis is made that the disease exists. By this timely surgery fewer deaths will occur than if left to nature or if left until the patient is dying before the operation is performed.

CASE IV. *Strangulated Femoral Hernia.—Operation for Radical Cure.—Recovery.*

Female, aged sixty-one. Has had an irreducible hernia for eighteen years. Thirty hours prior to the time I saw the case, she was taken with an acute pain of a prostrating character with an occasional short period of comparative freedom from pain. Her symptoms were the usual ones present in a strangulated hernia. She was sent to the hospital at once and a herniotomy performed. The incision was made in the usual way — in long diameter of the strangulated mass.

The sac was hard and blackened, so long had it and its contents been strangulated. On opening the sac a large amount of omentum was found which was so thoroughly compressed that all blood was driven from its vessels, causing the mass to look like a piece of cold beef's tallow. The gut was very dark and looked listless or dead.

The constriction at Gimbernat's ligament was "nicked" after guiding a probe-pointed bistory past its border. After dividing the strangulating band, a portion of the gut was pulled down and out of the opening, and hot water and aseptic sponges applied to restore the circulation, if possible, and peristalic function of the gut. After waiting for five minutes, I was gratified by seeing these expected and much-desired indications of intestinal vitality returning. Satisfying myself that the bowel could be saved by returning it into the abdominal cavity, it was gently persuaded to retreat into its natural abode.

The omentum was ligated with pure aseptic silk at its entrance into the abdominal opening, cut off and the stump returned into the peritoneal cavity. The sac was dissected from its firm attachments to the surrounding structures, ligated at its base or neck, and removed.

The femoral ring and canal were closed with silk-worm gut sutures, the overlying structures being stitched with the same material.

Her recovery was a perfect one, and the "care" all that could be desired. The operation not only saved her life from the effects of the strangulation, but cured as well her old hernia of eighteen years' duration.

Had I found the gut in this case so badly injured from the long pressure that the chances were against the possibility of preserving its integrity, I should have quickly drawn down a portion of the intestine after relieving the constriction, and made an interostomy; waited until my patient's condition was such as to justify and endure a prolonged operative procedure for the re-establishment of the normal fæcal circulation and a closure of the fæcal fistula.

CASE V. *Cancer of Cervix.—Vaginal Hysterectomy.—Recovery.*

Mrs. H., age thirty-two; mother of two children. A few months after birth of last child this lady consulted her physician relative to a "prune juice" looking discharge from the vagina. This one symptom being the only condition discovered by her that caused her to seek her physician's counsel and advice.

An examination revealed a cauli-flower mass projecting into the vagina and attached to the cervix.

The case was referred to me. I concurred with the medical attendant that the case was one of a malignant disease (carcinoma) of the cervix, and advised an immediate hysterectomy.

The operation was performed within a week, the patient making an ideal recovery, and has remained free from a recurrence of the disease up to this time — one year or over.

This case beautifully illustrates the necessity and advisability of immediate surgical interference and early recognition of malignant disease of the cervix as in other parts of the body.

The mortality attending a hysterectomy (vaginal) for malignant disease is very low—three to ten per cent.—and the percentage of recoveries (cures) from the disease is high when the work is done early. Various writers and operators placing the percentage of cures (non-recurrences) at from forty to seventy per cent. This is in accord with the modern and generally-accepted theory that cancer is of local origin, and that an *early* and complete removal of the primary foci bids fair to result in a permanent cure.

Hardly a week passes that I do not see one or more cases of cancerous disease of the female genital organs, and of this number very few are seen early enough to be classified as operable and curable cases. These cases must be recognized early and operated upon at once to insure good results and permanent cures.

A woman, presenting herself to a physician with a history of an inter-menstrual flow, or a woman, after the menopause, with a return of her "sickness" (?) (as she often thinks it is,) should be examined carefully, and not sent home with the advice that it is only the "change" working on her; that she will be all right as soon as she passes the change, etc., etc.

I have avoided entering into the minutiæ of the surgical technique in any of these cases, but will add that no bichloride of mercury or any other chemical antiseptic is ever used by me in my abdominal operations. Absolutely clean instruments, made so by washing and boiling them just before the operation; aseptic assistants and nurse (one of each is all that is necessary); clean (surgically) sponges and towels, used only for this class of work on a clean patient with as near a clean field of operation as it is possible to obtain. Quick surgery, short anæsthesia and a familiarity with the unexpected and unlooked-for complications so often met with in abdominal surgery, and the ability to quickly devise and carry out methods to meet these conditions will bring successes in the great majority of cases even though of the most unpromising character. Early work is attended with a low mortality.

Constipation.

Read before the Eastern Kansas Medical Society in Topeka, July 13, 1893.

By DR. F. E. SCHENCK, Harveyville, Kansas.

We present this subject to-night not because we have anything new or unique, but with the object of eliciting a discussion of a somewhat neglected subject.

Constipation is that condition of the bowel in which the dejecta are not frequent enough or occurring frequently enough are abnormally dry.

Thus defined, a good bit of latitude is allowed, and so we find it, for what is normal in one may be abnormal in another; one requiring one or two daily evacuations while another will suffer no ill if it occur only every four or five days.

Constipation may be the primary disease or merely a symptom of a constitutional disease, and as such we shall speak of it no further.

The causes of constipation are many and varied, but in all cases one or more of three conditions will be found, viz.: (1) insufficient or improper secretions whereby the intestinal contents are abnormally dry; (2) improper muscular action; (3) improper innervation.

The conditions under the first head may be brought about by an improper dietary, such as food containing an undue amount of an astringent, food in too minute state of subdivision, so that it is not sufficiently irritating to the gastric and intestinal mucous membrane; insufficient ingesta of liquid or too rapid absorption of the same, and various other causes. However the condition is brought about, the results are the same, viz., the intestinal contents lacking their normal lubricant, the stream becomes sluggish, and this sluggishness again tending to produce greater dryness as the absorbents still continue to take up the liquid portions and leave hard scybalous masses.

In the large intestines these masses tend to form in the pockets, and remaining in contact with the mucous membrane too long

time set up ulceration of one or more coats of bowel. If the ulceration is no deeper than the mucous coat, we will have more or less serous infiltration, and as a consequence paresis; if the process extends to the muscular coat, more or less of the muscular fibers will be destroyed, and as a consequence paralysis in proportion to the fibers destroyed.

The secretions may be sufficient in quantity and improper in quality, so that they do not give the proper stimulus to the bowel. The bile is said to have this property.

Where the muscular tonus has been weakened or destroyed, the vermicular action is impaired in proportion. As before stated, this may depend on deep ulceration or inflammation affecting the muscular coat of the bowel, or due to general wasting of the system, brought about by various constitutional diseases.

The third condition mentioned, viz., paralysis, may be brought about by those conditions which affect the nerve centers or the continuity of the conducting apparatus.

The former condition is found in all those diseases which impair or destroy the integrity of the cerebral centers.

The conductivity of the nerve may be destroyed by injury from penetrating wounds, neuroma, inflammation or pressure on the nerve, and in either case we have paralysis as the result.

Whatever the cause of constipation may be, the results are disastrous to the system, impairing the appetite and digestion, hebetude during the day and frequently sleeplessness at night where the accumulation is considerable. Pressure upon the inferior hemorrhoidal vein may produce hemorrhoids, congestion of pelvic organs and slight œdema.

The scybalous masses, remaining in contact for two long a time with the mucous membrane, set up ulceration, and, when sufficient irritation results, diarrhœa supervenes and the bowels may be entirely or only partially relieved, for we must remember that scybalous masses may still remain. After the diarrhœa stops, constipation again supervenes, these conditions alternating till relieved by art, or, being neglected, the bowel may eventually be unable to relieve itself, when we have complete obstruction with all its dire results.

Among other results may be mentioned headache, general malaise, the patient unwilling to undergo ordinary exertion, vertigo, disturbed vision, muscæ volitantes, tinitus aurium, palpitation of the heart and vague neuralgic pains.

Among the various affections which do not directly destroy life there is probably none that more severely test the skill of the practitioner than chronic constipation. One reason for this is that the habit frequently has been a long time in forming, and coupled with the fact that the worst cases often occur in old and debilitated subjects; but the great desideratum in treatment is the breaking up of this vicious habit and the establishment of proper habits. To this end all other measures should be subservient.

The bowels may be taught to act with the same regularity as the stomach, so that the desire to evacuate them will recur regularly, and when once established, should not be interfered with any more than regularity of meals; and we all know this is one of the first requirements in stomachic affections.

This time should be established to suit the convenience of the individual, and with most it will be the most convenient in the morning before the duties of the day begin and before the system becomes fatigued from the duties of the day.

The first measure to be recommended for the establishment of this habit is the diet; this should be strictly attended to, and such a diet advised as will increase the residuum unless there be other contra-indications.

Among these may be mentioned Graham flour, corn bread, oatmeal, fruits; succulent vegetables, as cabbage, lettuce, onions and others of this class.

Also the ingestion of more liquids, and especially to be recommended is the taking of a free draught of cold water when first rising in the morning, and to this may frequently be added a teaspoonful of sodium chloride.

In those of sedentary occupation, regular

exercise should be enjoined; in all, frequent bathing with friction and especially massage of the abdominal muscles, regular meals, regular hours for retiring and rising, regular time for retiring to the closet, and an attempt made whether the desire be present or not.

If these measures do not succeed, then other measures will be required.

The particular case in hand should be carefully studied, and, if possible, determine which one or what combination of the aforenamed conditions exist, and direct our efforts accordingly. If the secretions of the liver be insufficient, then the phosphate of soda, the triturate of calomel one part and milk sugar nine parts in ten-grain doses and repeated in six or eight hours is very efficient, or any other of the so-called cholagogues.

If the fault lies in the muscular apparatus, then such measures as will build up this system are demanded, and include iron, quinine, nux, oils, fats and a nutritious diet.

If the fault lies in the nervous system we must decide whether it is central or peripheral. If central, its treatment will be that of the central lesion; if peripheral, then we depend upon such remedies as strychnia, phosphorus and electricity.

In a great many cases the last two causes are combined, and especially is this true in the aged, and the trouble is located in the large intestines; but, wherever located, temporizing measures must be resorted to until the vicious habit can be overcome. A good combination for this purpose is aloes and asafœtida; also cascara sagrada; but the dose being so variable in different individuals is hard to regulate until a few trial doses have been given. Injections of water, alone or variously medicated, are often useful. Sometimes injections of oil will succeed; at other times, glycerine, either in the liquid or in the form of suppositories. Whatever the remedies employed, the dose should be as small and as seldom repeated as possible, and may be changed from time to time as the bowel becomes accustomed to the stimulus of any particular drug; but whatever the temporizing measures employed, we should always keep sight of the attempt to establish the habit of regularity, but with our best efforts we must acknowledge only partial success.

Secretary of the State Board of Health of Kansas.

The profession was disappointed when it was known that the governor proposed to change secretaries of the board.

Dr. O'Brien was well known, and his ability was unquestioned. His executive ability and knowledge of business in general, aside from his gentlemanly bearing and culture, made him peculiarly fitted for the position.

The change was made, however, and now, after some months' waiting and watching, it is admitted that the new populist secretary, Dr. Dykes, has fully met the most ardent expectation of his friends and the profession.

The new secretary has political sagacity, executive ability, a lego-sanitary medical knowledge, coupled with an evenness of temper and a patience borne of common sense, an untiring worker, which makes him a success in this new field.

With a little assistance from the physicians of the state, Dr. Dykes will be able to give us a report well worthy of the profession of medicine in the sun-flower state.

IN whooping cough or bronchitis, when the secretions are excessive, two or three drops of the fluid extract of belladonna, given every three hours, will afford relief.

THE ptyalism of pregnancy is benefitted by two drops of the fluid extract of belladonna three or four times a day.

APHONIA, due to fatigue, is relieved by atropia one-sixtieth grain.

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TOPEKA, KANSAS, OCTOBER, 1893.

Poor Pharmacy.

The general practitioner's responsibility to his patient does not end with the prescription he writes for him.

In the larger towns and cities, where there are from five to twenty druggists and his many patients patronize all of the stores, there is always one or more of the pharmacists who does not care, or does not know, or is too lazy to do his work properly, and the result is a mixture or a substitution which thwarts the object of the prescription and maybe does the patient positive harm. For self-protection the physician should acquaint himself intimately with the work of the pharmacist who puts up his prescriptions. If he cannot visit him personally in his laboratory, he can have the patient bring the medicine to him for inspection and trial. For example, the following simple prescription, as ordinarily put up in eye practice, is positively injurious even when indicated, and when intelligently prepared is one of the best remedies and universally known.

℞

Hydrarg. ox. flav.....grs. iv
Vaseline.....℥ i

M.

In the majority of cases it is simply mixed and not compounded. Look at it through a two- or three-inch glass and often with the naked eye, and the yellow crystals can be seen in the vaseline like so many wheat grains.

When such an ointment is put in the eye the crystals cut the mucous membrane and cornea, and a severe inflammation is brought on.

A case in point came under our observation some time ago. A doctor friend had severe ulceration of the cornea with threatened perforation. An atropiæ solution was prescribed—two grains to one ounce of distilled water. He had his druggist fill it. The solution was used in his eye, (a few drops every few hours,) but the eye grew worse. After using the solution a few days, the doctor said: "The atropine solution you use relieves my eye (a solution I carried with me and which I used when I visited him and made with distilled water), but what the nurse puts in of my solution burns and pains my eye."

I unkorked the bottle of his preparation and it was rotten. He directed me to the druggist, who said: "Yes, I put it up with distilled water. Well, just the same, it was melted ice and the ice was obtained from the river." We quit the use of the river solution, and the doctor, who lives in Topeka, will testify to the good results of the distilled solution.

Such is the case more or less in general practice, and when patronizing a new druggist—one who has not been tried and found competent and honest—the physician for his patient and his own protection should take the precaution to examine the medicine when put up. The patients or their friends will usually be pleased to take the medicine to the physician for his inspection. It is a double safeguard and reacts favorably upon

the physician when the patient sees the scrupulous care exercised by the doctor for the safety of his patient, and compels the druggist to do right.

THE Kansas Medical College began its fourth session and year September 19, 1893. Judging by former years, the number of matriculates will reach forty. The four years' study and three full courses of lectures of six months each required caused a few students to pass by the Kansas school and patronize one with easier requirements.

The school should be encouraged by the gradual increase in the attendance with the requirements of attendance made more rigid. The character of the work done by its graduates is proof positive of the thoroughness of the work done in the school and an encouragement to physicians to recommend the school to their students.

Some changes have been made in the faculty during the year. Drs. Rodgers and Donaldson resigned their chairs (anatomy and materia medica) to take positions at Los Cerrillas, N. M., in the medical department of the Santa Fe Railroad. Their three years' service in the school will be greatly to their advantage, as the schooling is to every man in it. Dr. Alkire takes anatomy and Dr. George L. Beers the materia medica; Dr. John Gilbert takes histology; Dr. R. S. Magee, physiology.

Graduates of this school are practicing medicine in Colorado, New Mexico, Dakota, California and Kansas.

It would afford the faculty great pleasure for physicians of Topeka and those calling in the city to visit the school often and see the work done in the college.

IN scarlet fever and measles, where the rash does not come out well, full doses of belladonna will generally give relief.

CASTOR-OIL applied to the warts once or twice a day for a few months will destroy them.

Married.

Miss Annabell Josephine Bauer and Dr. William E. McVey were married September 12, 1893.

The bride is one of the first ladies of Topeka. She is not one of your fine goodie girls, kept by the labor of parents, but she has been of some use in the world, having been book-keeper for Crosby Bros.' dry goods house of Topeka for the past seven years, making her own way in the world, dependent on no one, a true, independent America-Kansas girl.

The doctor is the publisher of the KANSAS MEDICAL JOURNAL, secretary of the Kansas Medical College, professor of Laryngology, Rhinology and Physical Diagnosis in the college; surgeon in the Kansas State Militia.

The doctor saw active service in the field last winter treating about fifty cases during the siege.

He came to Kansas from Illinois in 1885. We think this is a good showing for a young man, unaided by outside influence or money, dependent wholly upon merit.

We bespeak for the young couple success, extend our warmest congratulations and refer them to psalm cxxviii, verse 3, for our ardent hope.—ED.

Tobacco Habit.

Dr. Harger, in the October *Brig*, gives the following:

℞

Salæine.....
Cinchonidia.....aa..℥ i
Powd. ext. nucis vom.....
Sulph. quinine.....aa..ʒ i
Powd. hydrastis.....
Fl. ext. blood root....aa..m xxv

M. Make into 100 pills and take one three or four times a day, or when the desire for tobacco is strong.

An Impossibility.

General rules may be laid down to persons, but it is impossible and unsafe to lay down rules for health which may be safely followed by all persons.

The health depends largely upon diet. Some persons cannot eat fresh-baked bread; others cannot eat it when stale. Meat with some, especially fresh meat, produces congestion or fullness of the brain. Some persons cannot eat strawberries. A physician friend of ours can bring on a beautiful case of urticaria within a few hours by eating strawberries. In our own case, coffee and navy or Boston-baked beans, although taken with other food, eaten three or four meals in succession, will invariably bring on pyrosis. Banannas are considered to be an easily-digested food, but with some persons they are just the opposite. In general we can tell our patients to eat plain, nourishing food, easy of digestion, but it is well to find out the idiosyncrasy, if any, learn from the patient the kind of food that agrees with him and then encourage them to masticate it well, taking plenty of time, and limit the quantity to the medium amount, avoiding excessive amounts of fluid. Thus it is that each person must be a law unto himself.

In acute coryza, where the patient sneezes frequently and the discharge from the nose is free and acrid, and the eyes are suffused and the nose *snubbed* up, one-eighth of a grain of morphine and one-sixtieth of a grain of atropiæ will check the secretions, free the nose and make the patient comfortable. From five to ten drops of a solution of atropine (grs. ij to aquæ ℥ i) sprayed into the nostril two or three times in twenty-four hours will control the secretions.

Congestive forms of headache, where there is palor of the face, a full dose of belladonna will often give relief. Headaches from anæmia are made worse by the use of belladonna.

Report of a Case of Appendicitis.

BY DRS. MORTON & DROLL, GREEN, KANSAS.

Mr. A. C., male of twenty-seven years of age. Has always had the best of health. Has never been troubled with any irregularities of his bowels until last July, when after a long horse-back ride was suddenly attacked by a severe pain in his abdomen, and a slight diarrhœa.

Next morning was called to see him. He stated that about one hour before my arrival he had felt chilly. On careful examination found temperature 104°, pulse 100; regular and full, but compressible. Face flushed, tongue dry and heavily coated. Complete anorexia; some nausea; abdomen considerably distended and tympanitic. Some tenderness in right lumbar and iliac regions, also at McBurney's point; but on the most careful physical examination no evidence of a swelling could be detected. Suspecting a case of appendicitis, salines were given freely, but with poor results. On fourth and fifth days he felt some better, but on sixth and seventh days became very restless. Temperature 103°, pulse 100; bowels constipated and very tympanitic. On seventh day was seized with violent cramping pain in right leg, which was only relieved by morphine one-fourth grain, given every four hours hypodermically. On morning of eighth day operation was performed. Even at this time no evidence of a swelling could be found upon the most careful examination.

The extra-peritoneal operation was performed. One quart of pus was evacuated. The cavity thoroughly washed out with warm sterilized water and packed with iodoform gauze, which was repeated every day until healing of wound took place. No enterolith was found. The appendix was not removed on account of its numerous adhesions. Perforation of appendix near its attachment to cæcum had taken place through which fæces escaped for a few days.

Shortly after operation, pulse and temperature became normal. Appetite improved.

Was kept on liquid diet for a week and a half. Slept well and had complete absence of pain.

The external wound was kept open and the cavity allowed to heal from bottom by granulation. In two weeks recovery was complete. Two points of interest might be mentioned in this case, first, was the absence of the physical signs of the abscess; second, the cramping pains in right leg, probably due to pressure on the deep-seated nerves.

The Kansas Medical College.

One of the requirements demanded of the matriculate in a medical college belonging to the Association of Medical Colleges is that he shall be able to translate easy Latin prose. It is provided that students who are unable to comply with the Latin requirement may be given one year to make it up.

For the convenience of the students, the Kansas Medical College has employed a teacher who will give the necessary instruction in Latin free.

The success of the school has warranted the board of trustees at their last meeting, October 12, 1893, to order, by unanimous vote, the executive committee to have plans and specifications prepared by the next meeting for a college building.

Sufficient property and money was pledged to insure the building.

Despite the hard times and the four years' study and the three full terms of twenty-six weeks each required, the school will matriculate forty students this year.

DR. ASHMEAD says the Japanese children nurse until they are six years old. They do not use cow's milk, and this, in a great measure, accounts for the absence of tuberculosis among the people.

A RESULT of excessive meat eating is ill temper.

Hades.

Translators tell us the word *hades* means the grave. We are persuaded that this is true. Men and institutions do not, as a rule, willingly and knowingly dig their own graves; but it is through ignorance, avarice, false pride or mencenary motives it is often done. For the causes enumerated men will sometimes blast a name which it has taken time and labor and blood to establish. They become oblivious to the memory of the founders — the fathers — and to the children. They seemingly disregard every tie of memory's chain that reaches out and links the good name and honor of every child born in the household to the Alma Mater. They forget their manhood; they forget or cast aside every obligation which binds them to their fellow-men; they betray the trust imposed in them by the state and by those who have confided in them and chosen to go by their name; they fall to the low plane of the money getter, place seeker, charlatan and quack whom they affect to despise. For a paltry sum they are willing to and solicit men to come to them that they may have the degree of doctor of medicine conferred upon them, for the "admission is easy," as many will testify.

We have just received a circular-letter from such a school, sent to a prospective student, which is as follows:

"DEAR SIR.—Your name has come to us as that of a medical student. We hope you will carefully consider the advantages offered by this college before applying elsewhere, some of which are: Abundance of clinical material, utilized in the way most profitable to the student — that is, by instruction to small classes of ten each; a strong faculty, the members of which have had from five to twenty-four years' experience as instructors; a reputation for thorough methods and high standards in instruction; and an Alumni who have everywhere been successful and have required reputations of the highest character. With a board of directors, three of the members of which have been the officers of the college from the beginning,

a faculty composed of men whose earnestness and thoroughness in methods have largely contributed toward making the good reputation of the college, and with college property, real estate, building and equipment, practically without incumbrance, there can be no doubt that the future of the college will be even more prosperous than the past.

"We hope that you will visit the college at the beginning of the session of 1893–94, September 18, 1893, and become acquainted with officers and members of the faculty, and the students. We feel certain that you will be pleased and decide to matriculate with us. In doing so, you will find that our requirements for admission are not more exacting than those with which our many students in the last eight years have found it easy to comply, and that we fully appreciate that many applicants are not fresh from school. I am yours."

The strong faculty must be weakening or getting cornered, or some of the timber is giving way; for when a calf begins to weaken and you get him cornered, he bawls, and the first indication of a falling building is the cracking of the timbers.

Men and institutions are rated at their present value and not for what they have been or on their father's reputation. A good name is above rubies in value, and to be desired above all things; but it is un-American and anti-western, and impossible for a man or an institution to build up on the reputation another has made.

The Alumni of this wonderful "institoot" will be compelled to go elsewhere and take the adenudem degree while they are floating so high or they will soon experience the sickening proverbial thud so common to these high-flyers.

The beautiful, easy, sleek, go as you please, come when you will, old Mrs. Potipher seductive, unexacting requirements for *entrance* caps the climax—it there is one.

The appreciation of the ignorance of their fellow-man is *g*od-like, written with an italicised little g.

Taken all in all, this letter has the most pungent, odoriferous aroma of anything beyond a glue factory.

That any respectable alumnoy or physician would send or encourage a student to go to such a school to return in a short time to ignorantly trifle with human life and compete with them in their practice is not probable.

The various state boards of health and the reputable medical colleges, especially of the association, will repudiate such a school and the students from it. Unless the school sending out such a circular retracts or in some way sets itself right before the public and particularly the medical profession, it will soon be relegated to hades or be translated.

Salt and Health.

The *Northwestern Lumberman* gives the unusual exemption from disease of the workers in the salt works of Northern Michigan.

They are especially exempt from catarrh, pneumonia, tuberculosis and malaria.

It also relates the case of a physician who cured himself of consumption by the free use of salt independently of his food. He carried a box of it in his pocket and took frequent pinches.

It also cites the well-known health of those who sail upon salt water.

Are a Majority of Physicians and Surgeons Infidels?

In answer to the above question to Dr. Frank Locke's letter in the *Brief*, from thirty-four states one hundred and seventy-nine responses were received. The following were the questions asked:

1. Do you believe in the christian religion?
2. Do you profess it?
3. Are you a church member?

One hundred and fifty answered in the affirmative all three questions. Thirteen answered "no" to all three questions. This does not look like the majority of physicians were infidels.

South Kansas Medical Society.

Program for meeting to be held in Wichita, November 21, 1893:

1. Extra-Uterine Pregnancy — Laparotomy.—Dr. D. P. St. John, Wichita.
2. Treatment of Phthisis with report of cases.—Dr. W. E. McVey, Topeka.
3. Trachoma.—Dr. Flavel B. Tiffany, Kansas City, Mo.
4. Hysteria, with report of case.—Dr. H. D. Hill, Augusta.
5. Modern Surgery and its Technique.—Dr. A. L. Fulton, Kansas City, Mo.
6. Clinic.
7. Presentation of Pathological Specimens.—Dr. Emory Lamphear, Kansas City, Mo.
8. Paper on Genito-Urinary Diseases.—Dr. G. W. Davis, Kansas City, Mo.
9. A Paper.—Dr. J. A. Mitchell, Arkansas City, Kansas.
10. Address of retiring President.—Dr. J. T. Axtell, Newton.

Any information regarding the meeting will be cheerfully furnished by

O. B. WHITTECAR, *Secretary*,
Peabody, Kansas.

IN asthma, where the secretions are profuse and the breathing labored, give belladonna. It stimulates the respiratory centers and sympathetic ganglia, and lessens the secretions.

THERE is no one remedy that will overcome the incontinence of urine more frequently than belladonna. Children require large doses. From ten to fifteen drops of the tincture should be given in the evening.

PROF. ROBERT BARTHOLOW has completely recovered his health.

SURGERY.

The Surgeon's Assistant.

A good assistant is only less rare than a good surgeon. It is this fact that makes the surgeon dread to undertake work outside the wards of the hospital and causes him to hesitate even in cases of emergency. Modern surgery is essentially a co-operative art, and competent assistance and nursing are most necessary factors. The physician who summons a specialist or surgeon to his aid is by courtesy and common consent first assistant in whatever operative procedures may be entered upon, but how often that assistance is unworthy the name, or even worse than none at all.

Two elements enter into this failure on the part of the general practitioner to play well the role of a surgeon's assistant. The first — we beg the reader's pardon for mentioning it — is a failure to comprehend the meaning of *asepsis;* the second, a lack of dexterity in the detail of the most simple surgical handicraft. Concerning the first, too much has been written and said to hope that the reader's tolerance may bear further straining. The medical press teems with advertisements of efficient antiseptics and articles in proof of their value; our drug shelves are loaded with the antiseptic output of our chemical laboratories, and yet pus is not such an unheard-of thing as it might be, for all the antiseptics in the world cannot keep a man's hands clean if he persists in handling unclean things. What is commoner in the operating room than to see a man whose hands have just been submitted to a most elaborate cleansing, brush a fly off the bald spot on his head, or vigorously make use of his handkerchief or even extract a spectacle case from his pocket well underneath his gown and with those elaborately-prepared hands adjust a pair of glasses to his nose? These are little things, but somewhat incompatible with real asepsis, almost as much so as the too frequent failure

to remove every particle of the accumulation beneath the finger nails and as much of the nail as possible.

But it is the second element which seems to us to deserve particular emphasis. The recent graduate or over-busy practitioner can hardly be expected to be master of the details of an elaborate surgical operation, nor does he need to be able to follow every move of more skillful fingers, but he may know how to do four things and to do them well, namely: How to use the hæmostat, the ligature, the suture and the sponge. Familiarity with these demands repeated practice, and every doctor, be he young or old, far removed from the operating theater or within the pale of a college faculty, ought to obtain that practice. A rat or a small dog more or less will not create any disturbance provided it be done humanely, and dexterity can be obtained in no other way than by practice upon the living structures.

It is a nice thing to be able to close a spurting vessel by the first locking of the hæmostat, to pick up a single tissue, or to handle a needle without breaking out the eye. The man who is familiar with the forceps does not forget to lock them, nor is he constantly finding them made up of halves. And it is a nicer thing to throw a ligature around an artery forcep with just the right tension on the threads, which will let it slip clear off the forcep before tightening the knot.

The suture is perhaps of least importance, for in most cases the surgeon will handle the silk himself, though a simple interrupted or continuons suture, quickly and easily placed, ought not to be too great a task for any competent assistant.

But it is in handling the sponge that the good assistant shows himself, and a good sponger is an artist in very fact. One hears the most conflicting directions for the use of the sponge. To dab or not to dab seems to be the question with the weight of authority upon the dab. It really depends entirely upon the field of operation. The end in view is always the same—to leave a clean field for the operator without altering the relations of the parts. When that field involves divided muscles or sections of bone, a clean, firm wipe leaves the best results. Very small areas or deeper wounds demand the sudden pressure. Above all, a surgeon should never need ask for the sponge nor yet be under necessity of pushing it out of the way.

A good assistant does not become absorbed in watching the operator, but keeps an intent eye upon the changing aspect of the wound and the imminent need there, foreseeing small demands, such as for scissors, thread or forceps. Finally there is one quality worth more in an assistant than all the dexterity set forth above, and that is the ability to do what one is told to do and to continue in doing it, whether it be holding the staff or retractor, or work more tiring still. The man whose mind is on his own particular task is the invaluable man in the operating room, whose presence is an assurance of success.

J. C. M.

Suppurating Peritonitis.—Report of a Case and Laparotomy.

BY J. C. M'CLINTOCK, A.M., M.D., TOPEKA.

Mabel R., a young colored girl of fourteen years, was seen in consultation with Dr. R. E. McVey, May 24, 1893. The girl was found *in extremis*, temperature 103 4-5, pulse 154, respiration 40, and every indication of profound collapse. Her illness had dated from the 14th, and the history of the case pointed to appendicitis. There had been a sudden attack of peritoneal pain, limited at first to the right side, but gradually involving the whole abdomen. A tumor in the right iliac region had been easily made out, cæcal obstruction diagnosed, and salines administered. The bowels had moved freely, the peritonitis subsided, and the pain and tenderness became limited to the region of the cæcum. A well-defined tumor had persisted in that region throughout the sickness. May 23d: temperature normal, all other conditions favorable, and the indications seemed to point to a speedy and satis-

factory recovery. About 6 o'clock on the morning of the 24th, the patient was seized with extreme pain and began to vomit, growing rapidly worse from that time until 3 o'clock in the afternoon, when the doctor summoned counsel.

The abdominal muscles were found tense and rigid, every touch aggravating the pain and increasing the shock so that any examination was impossible. The case was therefore received upon its history, and the collapse attributed to the bursting of a perityphilitic abscess. An operation was suggested as offering a bare chance in a condition where death was imminent. It was not urged, as it was thought that even though the abdomen should be washed and drained, enough pus had already been absorbed to make the collapse permanent. After an hour the patient was again examined; the pulse rate had decreased to 145, other symptoms remained the same. An hour more and the pulse had gone down to 140, and it seemed best to give her the benefit of the chance. There was no possibility of antiseptic preparations of any kind; the surroundings could not have been more unfavorable, and the surgeon could never be asked to work in a dirtier room. The patient was hastily prepared and placed upon the kitchen table, a small quantity of chloroform administered, and the abdomen opened over the cæcum. The tissues were very much inflamed and matted together, the appendix adherent, and in one spot the intestinal walls were evidently thinned as if from external ulceration, but no perforation was found and no pus cavity, though the presence of pus was clearly manifested in the condition of the serous surfaces. Exploration was rapidly made into the pelvis, through adherent intestines and much inflammatory matter. The right ovary and tube were exposed, and an extremely offensive pus was found pouring out of the tube, which was so rotten that the slight tension necessary to bring it into the wound tore the tube completely in two. A double ligature was thrown around both portions, close to the uterus, and the ovary and tube amputated.

At this point a complication arose which may possibly explain the reason for secondary hemorrhage after apparently favorable operations. The stump was just being returned to the abdomen in the haste made necessary by the condition of the patient, though the usual care had been exercised to look well to the cut vessels before doing so, when an artery spurted; not from the surface of the stump, but from beneath the ligature, where the silk had cut through the rotten tissue. Again a shoemaker's stitch was passed through the pedicle, tightened, and a dry stump returned; but meantime the patient had succumbed. Respiration had ceased and she was apparently pulseless. Prompt measures were adopted for resuscitation, the chloroform withdrawn and strychnia and digitalis administered hypodermically. As soon as the patient began to breathe, the left ovary and tube were delivered without further anæsthesia; the same condition found and extirpation effected. The abdomen was then thoroughly irrigated with hot water, reviving the patient from the profound collapse, a drainage tube inserted and the rest of the wound closed. She was put to bed, and in a half-hour was in a better condition than at any time since first seen. The tube should have been drawn with a syringe every few minutes, but the surroundings were such that it seemed a better plan to allow it to drain imperfectly into the dressings rather than expose the wound to that atmosphere.

At 10 o'clock that night her pulse was 136. Respiration and temperature much the same, but the pain was quite relieved, so that the patient was breathing much more deeply. The next day she was decidedly better, and a little nourishment was retained. The peritonitis subsided and adhesions took place, so that the drainage tube was completely walled off from the abdomen. The discharge was offensive in the extreme, evacuating large quantities of decomposing pus and necrotic tissue. The wound was dressed frequently, washed out with boracic acid solution. By the tenth day all the ligatures had been washed away.

The patient continued to do well, showing no further peritoneal symptoms. After the third week her mother was able to care for the wound, and by the sixth week the girl was down town, and yesterday she was working in the field husking corn.

Lupus: Its Extirpation.

Dr. B. Merrill Ricketts, of Cincinnati, in the *N. Y. Medical Journal*, No. 13, says:

"So much has been said about this disease during the last three years by men who have spent the greater part of their time not only in treating it, but in studying its pathology, that it might seem preposterous for one with limited advantages to offer anything new whatever concerning this much-dreaded disease. The ravages that it produces and its persistent character have made not only the sufferer but the surgeon desperate. Considered in the light of experience, it is not strange that the treatment of to-day gives but little relief. Koch has perhaps more nearly approached a panacea for lupus than any other investigator. Whether or not the future treatment and consequent good results are to be obtained by following up his principles is yet a question.

"The question arises, When does it become constitutional, and to what degree may it become constitutional when extirpation would be useless? It is also important to determine that degree in any of the malignant growths. If lupus is found upon the finger, we would not hesitate to amputate it; if lupus were to appear upon the hand, we would naturally resort to all means of treatment to save the hand. Would it not be better to remove the hand early in the progress of the disease? We know that the removal of a finger affected with lupus has cut short the disease, and that the patient has lived for years without any recurrence. Now, if this is so, why is it not rational surgery to extirpate any diseased lesion that may appear upon any part of the body? The means that we now have at our command in restoring parts with both single and double pedunculated grafts should encourage both the operator and the patient in resorting to early surgical interference, no difference upon what part of the face the disease may be found. The dread of suffering, taking an anæsthetic, and being deformed, I might say, is the occasion of so much procrastination, not only in the treatment of lupus, but all other diseases. What are we to do with these unfortunate creatures when they present themselves to us for treatment? Are we to tell them that nothing can be done, that it is folly to attempt to relieve them? Believing, as I do, that all diseased tissue should be removed when possible, I have been led to extirpate lupus on several occasions with most gratifying results.

"Even in cases of multiple lupus I would advise their excision if the areas affected are small. Whether this plan of treatment should be limited is a question with the operator. So far I have seen but three or four cases of multiple lupus. I am quite sure that in each case good would have resulted from the extirpation of the lesion which either one of them possessed. Would it not be well for us to draw a halt in saying that there is nothing to be done in cases of lupus? I believe that the pendulum should be swung in the opposite direction, and that the preponderance of evidence at the present time fully justifies this statement. Even though the disease should recur, it is not until quite a length of time has elapsed. I believe that the end justifies the means, and that it is humane to subject these unfortunate patients to the operation of extirpation, even though the relief be but for a short time. This, of course, requires more judgment in case of lupus upon the various parts of the face. I have presented the subject to see if it cannot be brought more prominently before the surgeons—that is, the operations of extirpation. I think that the cases I have reported, and the subsequent good results from extirpation, fully substantiate what I have said. Possibly I am deceived in my diagnosis, but I am thoroughly convinced in my own mind

that I am not. I do not mean to be understood as saying that the disease will not recur in either one or all of the cases; surely I could not be so foolish as to say that. I propose to extirpate lupus, if possible, wherever found. I believe if this is done that a great deal of suffering, disfiguration, and, I might say, loss of life will be prevented."

I have made a somewhat lengthy extract from Dr. Ricketts excellent paper for the reason that his experience has so nearly coincided with my own, and the conclusions which he reaches are those with which I can heartily agree. Early in my practice I became convinced that any method of dealing with true lupus, other than total extirpation, is unsatisfactory in the extreme. In speaking of lupus upon the extremities, the doctor questions the advisability of attempting to save the hand when affected, and asks: "Would it not be better to remove the hand early in the progress of the disease?" I cannot think so, but believe that even an extensive lesion of the hand may be completely removed by wide excision and careful dissection, and no recurrence take place. While I should not hesitate to amputate where I believed it to be the only chance, yet I should reserve amputation in lupus as indeed in everything else for a last resort. One case in my own operative treatment of lupus illustrates this point.

A female, aged seventy-three; the back of the left hand covered with a well-developed lupus. It extended down over the two middle fingers, and there was a spot upon her arm and three on her face. A radical operation seemed at first unadvisable, owing to her advanced age, so the curette and pyrogallic acid were employed without great expectation of a permanent cure. The entire surface was scraped clean, however, and healed kindly in four weeks' time. Six weeks later it showed signs of returning, and the old lady treated it herself with a seventy-five per cent. solution of carbolic acid, burning it deeply. The wound became infected and she returned to me with a very ill-looking hand. I curetted again, thinking that nothing but amputation would stay the disease, but again an apparently healthy cicatrix formed. Ten days later I saw that the disease was under headway once more. No pus had formed, but the granulomata were typical. Then I made a complete eradication. Under ether the skin and cellular tissue were dissected off, going down on the fingers, and even at one point into the sheath of the exstensor tendons. The wound was closed by three skin grafts from above the elbow, and a simple cotton dressing applied. Four weeks later the patient went home with a healthy hand and good use of her fingers. It is now nearly two years since the operation and there has been no return.

Dr. Ricketts advises the extirpation of all small spots in cases of multiple lupus. In general I would agree with him, though in this case, as I have said, there were small patches upon the face—one on the nose and on either cheek, where her spectacle rims rested. The largest of these was curetted and cicatrized under the treatment. The other two were not molested, as their development had been very gradual, their progress too slow to be noticeable in the time during which she was under my care. I thought it most probable that she would live out her life before they occasioned her any inconvenience.

I would say further that I consider Dr. Ricketts' position well taken, as is proved by the excellent results in the cases which he reports, and if his effectual treatment were more generally followed by surgeons everywhere the disease would rarely go on to ineradicable cases.

J. C. McCLINTOCK.

DISEASES OF RESPIRATORY ORGANS.

Treatment of Phthisis.

In the treatment of tubercular phthisis we should not be so zealous in the use of germicides that we forget the general conditions of the patients. The true and successful

scientific treatment of this most dread disease is the one which takes cognizance of the conditions already present rather than the causes of the disease.

The hectic, the wasting, diarrhœa and other prominent symptoms of the disease are probably those which we find in any abscess with purulent absorption. They are the result of the breaking down of lung tissue and absorption of purulent matter by the blood. If we found these conditions caused by abscess in some other part of the body, we would at once direct our attention to evacuating the cavity, and we would place our patient upon reconstructive remedies and nutrient foods in order that the general condition may be improved and the lost tissue be restored. The rational treatment of an abscess in the lungs is based upon the same indications. An abscess in the lung usually has a natural outlet—a bronchi into which it opens. Our purpose, then, will be to assist in the natural process of evacuation and to place the cavity in as nearly an antiseptic state as its location will permit. Some cough is necessary to expell the contents of the cavity, but the irritating hacking which annoys the patient and prevents sleep is unnecessary and should be relieved by properly-directed remedies. Frequently-repeated inhalations of creosote in albolene will relieve the irritation and aid in the expulsion of matter from the lung, and at the same time render the cavity nearly antiseptic.

The salvation of a phthisical patient is the maintenance of a good nutrition. There is always a possibility, where the cavity is not too large, that it may heal up, and even in large cavities if sufficient resisting power can be established, the breaking-down process may be checked, and though the cavity remain, the amount of pus will be greatly diminished, granulations form and an impermeable wall established between the cavity and healthy lung tissue. This condition may exist for years without greatly disturbing the general health of the individual. The three most prominent indications for treatment are the suppurating lung, the irritable cough and the loss of nutrition. For the first, inhalations of creosote in albolene, thirty drops to the ounce, inhaled by means of a nebulizer with a good face shield. The globe nebulizer is the most satisfactory. The sittings should be repeated two or three times a day, and should last about five minutes. After a few inhalations, the cough is less irritating and the expectoration diminishes and very frequently the cough will only return when the cavity has filled up. Where the cough is very irritating, the following is very efficient in the beginning:

Tr. opii camph.....ʒ ij
Treacle.....ʒ i
Rum.....ʒ i

M. A teaspoonful of this to be given every three hours. It is a very pleasant mixture and usually answers the purpose of the more elaborate cough mixtures.

For reconstructive agents cod-liver oil heads the list, provided it can be properly digested and assimilated, otherwise it is worse than useless.

The action of cod-liver oil should be carefully noted, and if under its use the stomach becomes irritable or the bowels loose, an alteration should be made in the preparation. We have found that by adding to our cod-liver oil emulsions, creosote or guaiacol it does not ferment in the stomach and cause those disagreeable eructations; and, on the other hand, the creosote in combination with the oil is less likely to irritate than when administered in any other form. A very pleasant and efficient emulsion, containing cod-liver oil, guaiacol, lactophosphate of lime and wild cherry is now prepared under the name of guaiacoline by the Kaw Pharmacal Co., of Topeka. It is an excellent preparation and well adapted for these phthisical cases.

In the matter of foods we would insist upon a liberal meat diet, prescribing in addition to the regular meals from one to two pints of expressed beef juice daily.

Tonsillitis.

We should be more careful in the diagnosis and treatment of acute diseases of the

tonsils. There are three forms of inflammation of the tonsils, involving the parenchymatous tissue, peri-tonsillar tissue or the secreting tissue accordingly. In the former we most likely have an abscess either in the center of the tonsil or outside of it in the peri-tonsillar tissue. Where the secreting structure is involved, we have the form usually recognized as follicular tonsillitis, sometimes erroneously called diphtheritic sore-throat. In this form one or more follicles are the seat of the disease, and it is very easily distinguished from diphtheria from the fact that it is limited to the follicles.

Local and General Treatment of Hay Fever.

This was the title of a discussion opened by Dr. D. Bryson Delavan, of New York.

Dr. Price-Brown, of Toronto, had himself suffered from the malady. He discovered sensitive areas in his own nostrils, which he cauterized. Afterward he removed a portion of his own uvula, which seemed to be the starting point of reflex disturbance. Alumnol solutions had relieved one attack. He gave his patients weak cocaine solutions, but always dispensed them himself, and followed it up with menthol in albolene, five to twenty grains to the ounce.

Dr. J. O. Roe, of Rochester, had found a local intra-nasal lesion in every case of hay fever. He doubted the existence of the so-called general "neurotic" cases. Free nasal passages by no means necessarily meant healthy mucous membrane. There is or has been at some time intra-nasal pressure, and its removal is necessary for successful treatment. Nasal trouble may set up lesions in other parts, which persist after the primal cause is taken away. He regards the cautery as good only in vascular turgescence. Only the point of a projecting turbinated, giving pressure, should be taken off, and never the entire bone.

Dr. S. S. Koser, of Williamsport, Pa., finds terebene internally of service. Also, as a sedative measure, inhalations of carbolic acid and camphor in chloroform. We should always palliate before we operate. He chips the bone, as he does not regard the cautery permanent enough in its effects.

Dr. James E. Logan had had an experience practically identical with that of Dr. Roe. He used the cautery before the paroxysm, and gives pills of nitrite of sodium with camphor internally for six or eight weeks after the attack is over.

Dr. J. H. Bryan, of Washington, D. C., thought that there must be two different conditions comprised under the term hay fever. Otherwise we would not find such diametrically-opposed views as to its underlying pathology. He believed that it was impossible to permanently relieve the so-called "neurotic" cases.

Dr. E. Fletcher Ingalls, of Chicago, uses the cautery two or three weeks before the attack, so as to have healing complete before its onset. He employs it superficially, like a blister, so as to avoid the formation of cicatricial tissue. Internally he gives phosphate of brucia, camphor, hyoscyamus, quinine, etc., beginning one week before the attack.

Dr. John N. Mackenzie was glad that no one had spoken of the "pollen" theory as to the cause of the malady. It has been, in his opinion, a bar to the proper conception of the disease. He stated that he sees cases where there is no lesion in the respiratory tract in the intervals between the attacks. Pressure irritation he believes more liable to produce atrophy than hypertrophy. The various forms of rhinitis, hyperæsthetic, vaso-motor, etc., should all be classified under one heading. He employs nerve tonics, such as quinine, phosphide of zinc and nux before meals, with Fowler's or Donovan's solution of arsenic after meals. Such a treatment will often clear up mild cases. If disease occurs in any part of the respiratory tract, it should of course be removed. The cautery should be applied to any sensitive areas.—*Medical Record.*

ADVERTISE in the JOURNAL.

The Bacteria of the Respiratory Passages.

The respiratory passages being freely in communication with the external air on the one part and with the saliva on the other, are naturally continually exposed to microbic invasion. According to Pettenkofer, among all the various ways by which pathogenic organisms can gain entrance to the animal organism, the lungs occupy the chief position (*Medical Press*). In the normal state—that is to say, when the integrity of the passages is complete—no microbic infection takes place, but the case is different when any lesion of the mucous membrane exists. In the nasal cavities of eighty-one persons examined, the mucus obtained therefrom contained pathogenic as well as non-pathogenic bacteria. Among these persons were six medical men engaged in laboratory work, eight domestics, four soldiers and twenty-eight convalescents. There appears, therefore, to be no doubt that even in the case of the healthiest men the nasal fossæ become, as it were, the storehouse of a large number of microbes of various species, some of a virulent character, which are ready at the first opportunity to create mischief in the respiratory passages. Besser has studied the bacteria found in the larynx and bronchi, and for this purpose he examined the bodies of many persons shortly after death. In the mucus of the larynx in five cases he detected the streptococcus pyogenes; in the same case the staphylococcus dore was present three times and the micrococcus albus liquifacients four times. So far as the normal bronchial mucous membrane is concerned, the number of bacteria is not so considerable. In ten cases examined after death the streptococcus pyogenes was found twice, the diplococcus of pneumonia thrice, the staphylococcus aureus thrice and the bacillus of Friedlander once. Thus there is evidence to show that the microbes of pneumonia and of suppuration can survive in the bronchial secretions without causing any pathological changes in the lungs. The question then arises, how it is these microbes are able to display their virulent effects. Undeniably the influence of cold in the majority of cases has much to do with this result. From the inhalation of cold air bronchitis is produced, and with the sudden chilling of the body, while in a state of perspiration, nutritional changes are caused, which in each case affords the microbes the opportunity of asserting their virulence.—*Medical Record.*

Dog's Blood in Pulmonary Tuberculosis.

Recent experiments have been made at Naples with the use of serum from dog's blood. The blood is first secured by opening the carotid under thoroughly aseptic methods. It is allowed to coagulate, and the serum is drawn off. This is then carefully sterilized by a heat of 37° C. for two days. It is then injected hypodermically, the amount varying from one and one-half to two and one-half grammes.

The results were somewhat uncertain, though in two of the cases there was marked improvement and an entire absence of fever following the injections.

Strychnine in Diseases of the Respiratory Organs.

Dr. Thos. J. Mays in the *Medical News* claims excellent results from the use of strychnia in pulmonary disease. He says it lessens the amount of cough and expectoration, relieves difficult breathing and nervous restlessness. He also says it produces in the patient a marked tendency to put on flesh. The size of the dose to be given is of great importance. The dose should be, to begin with, one-thirty-second of a grain four times a day, which should be increased to one-seventh or one-sixth of a grain four times a day.

He usually prescribes it in connection with phenacetine and atropine.

In asthma an injection of one-thirtieth grain, given in the evening, will aid in preventing the attack. Doses of one-thirty-

second grain in half a fluid dram each of hydriodic acid and syrup hypophosphites four times a day. This should be continued till a decided impression is made. The same prescription is also useful in convalescents from pneumonia.

GYNECOLOGY.

How Shall We Close the Abdominal Incision?

BY M. B. WARD, A.M., M.D., TOPEKA.

In a recent paper read before the American Association of Obstetricians and Gynecologists, Dr. H. W. Longyear, of Detroit, Michigan, has given us some important data which I consider of sufficient import and interest to the general practitioner to briefly review in the JOURNAL.

"The frequency of the occurrence of hernia following abdominal section, resulting from imperfect union of one or more of the respective layers forming the abdominal wall, indicate an evident lack of correct technique, either in the methods used or by their improper application, and seem to demand, for the future, more perfect work of aspirants to surgical fame. The general technique of abdominal surgery has now become so perfected as to cause the mortality per cent. to be reduced to such a low point that the disputes on the vital issues will soon cease for want of food, and be succeeded by those related to the perfection of the art. Soon the question will not be: 'Did she recover?' but 'How did she recover?' The surgeon who not only saves his patient's life, but so performs his work as to leave her body in as perfect and natural a state as assisted nature can make it, will be deserving of the greatest merit. I do not think I am asserting more than is warranted by the evidence adduced by the advance in other branches of surgical technique when I predict that the time will speedily come when the occurrence of a hernia following an abdominal section will, with very rare exceptions, reflect on the skill of the operator, and be looked upon as the result of bad mechanical work.

"*Tendonous tissue requires, under favorable conditions, from four to eight weeks' time to become firmly united.*"

In order to obtain the methods employed by some of the great operators, Dr. Longyear addressed the following-named gentlemen, who kindly and frankly answered his questions regarding their methods of closing the abdominal wound and their technical points in abdominal operations: George Granville Bantock, T. A. Emmet, Henry O. Marcy, A. Martin, Joseph Price, Aguste Reverdin, Max Sanger, Thomas Savage, A. J. C. Skene, J. Greig Smith, T. G. Thomas, F. Winkel. I will quote them in the order named, the letter of Dr. Bantock coming first.

Dr. Bantock says: "In the majority of cases I close the abdominal wound with sutures, including the whole thickness of the wound, but only including a small portion of the muscle. I include a good quarter of an inch of skin, but only about an eighth of peritoneum. When the incision extends beyond the umbilicus, I go straight through the structure. In these cases I divide the tissues between the skin and peritoneum so as to obtain a nearly uniform breadth of raw surface for the whole of the upper portion of the wound. I trim the skin into a straight line, then I bring the peritoneum together by a continuous suture of very fine silk-worm gut or cat-gut from the upper angle of the wound to about an inch below the umbilical region, and complete the wound with sutures, embracing the whole thickness of the wound, just catching up the peritoneum so as not to leave a pocket. In cases of hysterectomy by the extra-peritoneal method, I bring the peritoneal surfaces together behind the serre noeud by a suture of fine silk-worm gut, which goes first through the peritoneum on one side and a quarter of an inch from the edge—*i. e.*, entering on the secreting surface and re-

turning the same way—then through the uterine peritoneum and again through the peritoneum on the opposite side. When the suture is tied, it brings two broad surfaces of peritoneum together in apposition to one another and to that covering the lower segment of the uterus (cervical portion). I then bring the edges of the peritoneum together by two, three or four sutures of cat-gut, thus closing the lower angle of the wound (above the stump) by two rows of sutures, as in the case of the upper part. In all cases, for the main abdominal sutures, I use silk-worm gut, which I have advocated for over twenty years.

"The buried suture is of great service in certain cases, but it is not necessary in the majority of cases. Allow me to add that silk-worm gut is the best material for the usual abdominal suture. As a rule, it is also best for the buried suture, especially if there be much tension. But it is essential that the wounds should heal by first intention.

"For many years I have used only silver wire, and always close the wound with as much care as a piece of plastic work. Two or three times I have brought the peritoneum together with the buried sutures in addition to the silver wire, and in each instance an abscess formed, giving a great deal of trouble."

Dr. Henry O. Marcy, to whom we are chiefly indebted for the kangaroo tendon suture, says: "During the last eight years I have employed exclusively the buried suture in the closure of all abdominal wounds, except for a few months, during which time cat-gut was substituted for tendon, because of the difficulty of obtaining a supply of tendon from Australia. For more than ten years preceding I had used the buried animal suture in a great variety of wounds, and was led to its adoption in laparotomy because of its exceptional value in the reinforcement of the weakened structures, especially as demonstrated in operation for the cure of hernia. My method from the first has been essentially the same. The peritoneum is first closed separately; this may be effected by suturing in a variety of ways. For ease and rapidity, if for no other reason, the continuous suture is to be preferred. I employ, usually, the double continuous suture, which is easily and rapidly taken by the use of a curved needle with the eye near the point, and by re-threading with the opposite end, the suture is introduced from either side through the same puncture. The result is an even, continuous, close apposition of the serous surfaces of the peritoneum, retaining at rest without undue constriction. A fine tendon should be selected for this purpose. When one of the recti has been separated, as is usually the case, it is better to rejoin the muscles by a row of sutures. This having been effected, I consider the accurate co-aptation of the thick investing fascia (linea alba) of the first importance. This is preferably effected by a line of sutures similar to the one closing the peritoneum. The more or less thick layer of fatty tissue is preferably brought into apposition by one or two light lines of running sutures, usually taken with a medium-sized, fully-curved Hagadorn needle, introduced from side to side deeply through the uninjured structures. Care is taken that the introduction of the needle commences exactly opposite the emergance of the preceding stitch, the importance of which is two-fold: First, that the co-aptation of the wound may be accurately effected; and secondly, of not less importance, that the suture itself may cross at right angles to the divided tissues, so that when drawn upon it accurately coaptates the lips of the wound and is not interposed between the injured parts. The skin is united by the use of a fine, full-curved Hagadorn needle, and a small tendon suture, introducing the stitches in precisely the same manner just described."

Dr. A. Martin, of Berlin, writes as follows: "I apply five to seven sutures, including skin, connective tissue layers, muscles and peritoneum. Between these five to seven sutures, superficial cat-gut sutures close the skin wound. No vessel ligatures, no drainage, interrupt the incision wound. Compress bandage with cotton, wool and gauze binders. For nine to ten days consequent

dorsal decubitus. The silk sutures are removed the eleventh or twelfth day. Patients sit up the thirteenth day, leave bed the fourteenth, and return home according to their home comforts."

Dr. Joseph Price, whose rich experience in abdominal surgery is probably unequaled in this country, testifies as follows: "I close the incision with silk-worm gut or silk, interrupted, three or four to the inch, through the entire thickness of abdomen. Have exercised more care than is common in closure of incision."

Dr. Auguste Reverdin, of Geneva, Switzerland, writes: "My practice is to sew the peritoneum with interrupted sutures of cat-gut. Over these sutures, approximating very exactly the serous membrane, I place the second series approximating the recti abdominalis and their aponeuroses (also with cat-gut). Then, finally, a third layer of sutures close the skin, for which I usually use silk, disinfected by boiling in a five per cent. carbolated solution or silk-worm gut, disinfected with corrosive sublimate. For these cutaneous sutures I use, indifferently, either continuous or interrupted suture. When the abdominal walls approximate with difficulty, or are very thick, or I have any special reason to desire a more solid union, I use either Girard's suture or else separate sutures of strong silk, each passing by itself (isolated) through the entire wall. But what I seek for mostly, for future solidity, is to approximate exactly tissues of same kind—serous to serous, muscle to muscle."

Dr. Max Sanger, of Leipsig: "I close the abdominal incision simply with deep and superficial sutures when the whole thickness of the wall does not go beyond two to two and one-half centimeters. For sutures I use *only* aseptic Chinese silk (not the braided kind, the so-called Turner silk, which, on account of its braiding, is harder to asepticise). The peritoneum is included rather broadly in the deep sutures, which, however, on the cutaneous side are entered and brought out in the near vicinity of the wound lips. As to the aponeurotic membranes, which have a tendency to retract, they must be looked after and positively taken up in the suture. The distance between sutures averages one and one-half centimeters. When the abdominal walls have a thickness of more than two and one-half centimeters or a specially solid suture is required, as *e. g.* after radical cure of ventral hernia,) I insert between the regular deep sutures, which pass through all the layers of the abdominal wall, half deep, buried sutures, (also *always* silk,) which all include the aponeuroses."

Dr. Thomas Savage, of Birmingham, England, writes as follows: "I always use scalded silk sutures with a needle at each end, and pass through peritoneum and the whole thickness of the abdominal wall."

Mr. J. Greig Smith writes as follows: "I employ the method of abdominal suture described in my book on 'Abdominal Surgery,' viz.: one suture (silk-worm gut), including all the tissues—skin, fascia, muscle and peritoneum—but dips deeply into muscle and fascia. The suture is so inserted that it leaves a *pouting* and not a *depressed* margin along the incision."

Dr. T. C. Thomas writes: "With chromicized cat-gut and interrupted suture I close the peritoneum, recti muscle and sheath of the same. Before doing this, I pass deep sutures of silk-worm gut or silver, but don't tie. Then (*i. e.*, after closure with cat-gut) I close the whole wound. Results have been good as to abscess and hernia. I sometimes close the peritoneum separately and then the muscles, but I see no great advantage from this."

Prof. Von Winckel, of Munich, writes: "I sew the peritoneum with cat-gut, the muscle with silk, and the skin with silk-worm gut."

While it is true that we should endeavor to close the abdomen that the percentage of hernias may be reduced to the minimum, we should also have in mind other complications which are also to be dreaded. My method, up to this time, has been to close the entire wound by the use of silk-worm gut or silver wire, and I have no reasons to change this plan in order to adopt the various methods referred to in the foregoing quotations. I think that it is possible to so unite the wound by properly-adjusted

silk-worm gut sutures that hernias should never occur unless from some unusual accident.

What, then, shall we understand by properly-adjusted sutures is the all-important question. The sutures, if of silk-worm gut, should be carefully selected from the best material in the market. Long, straight needles are preferable to curved ones in closing the incision. The sutures should be placed near each other.

I pass the needle through the skin quite near the cut surface, and then avoid the adipose tissue as much as possible, but very careful to include in the sweep of the needle sufficient quantity of the muscles and fascia to insure a firm hold, and when I reach the peritoneum, the needle is passed through as close to the edge as possible. My desire is to avoid the rolling up of the peritoneum, as it is certain to separate the stronger tissues and prevent their union.

If one is cultured in the technique of closing the abdomen by this method there can be no question but that one may replace the tissues in their natural position. It seems to me that nothing can be more easy to understand than the fact that if we have placed the tissues as nature intended we should, and can retain them there until union is formed, all the indications are met and nothing more can be done. The silk-worm gut or silver wire should be left in situ for at least fourteen days. There is no reason why they may not be left for three or four weeks, thus making the union still stronger. In addition to the sutures it is my custom to apply some adhesive straps as an extra support; after this the many-tail bandage is applied as tightly as possible during the entire convalescence. This bandage should be tightened several times a day, so that there may be no opportunity for any unusual strain to come upon the sutures.

Next in importance to the prevention of hernia is the avoidance of any step which may leave behind septic material that infect the deeper tissues, as they are quite as distressing to the patient as hernia. In some of the abdominal work which comes to us it is of course necessary that buried sutures should be used, and then our choice must be made between absorpable and non-absorpable suture. I have never used the silk-worm gut as a buried suture, fearing that it would act as a local irritant, thereby causing suffering, if nothing more serious.

The kangaroo tendon, as furnished by Dr. Marcy, is the safest material for buried sutures.

I do not think it possible to make any absorpable substance absolutely aseptic, therefore there will always be a slight risk in leaving animal sutures buried in the tissues.

In conclusion, then, I would recommend that all incisions of the abdomen, so far as is possible, should be closed by the use of silk-worm gut or silver wire interrupted sutures, and when, as in hernia operations, it is found necessary to use buried sutures, the kangaroo tendon meets the indications as well as any suture yet discovered.

NEW REMEDIES.

Pyrozone.

The name Pyrozone is applied by the manufacturers to "H_2O_2 Absolute." Pyrozone three per cent. solution will describe intelligently a solution of Peroxide of Hydrogen, which answers the test of the new U. S. Pharmacopœia, and improves on the product of its process by a solution which is pressureless and permanent, losing none of its energy until it is required in the presence of extraneous organic matter. The absence of decomposition or ebulition is evidence that the last measure of fluid in every bottle will be no more irritating than the first portion, consequently the objections offered against "Solutions of Peroxide of Hydrogen," erroneously called "Peroxide of Hydrogen," will be overcome, so far as they relate to instability and consequent acrid and irritating characteristics.

The many and important uses of Pyrozone five per cent. solution (antiseptic) and Pyro-

zone twenty-five per cent. solution (caustic) are described in a pamphlet on the subject.

Among the many physicians who have used and appreciated the value of Pyrozone we may mention a few: Dr. Holbrook Curtis says (*N. Y. Therap. Review*): "In my opinion this new compound of hydrogen dioxide twenty-five per cent. (ethereal). Caustic Pyrozone promises to take an important place in nasal and throat surgery. With none of the very depressing and oft-times ill effects of chromic acid and the lesser evils of tri-chloracetic, Caustic Pyrozone seems to offer a quite efficient substitute, doing a maximum of work with a minimum of discomfort. As an application to polypoid tissue and for the reduction of hypertrophies it is invaluable."

Dr. A. H. Ohmann-Dumesnil speaks highly (*St. Louis Clinique*) of the value of Caustic Pyrozone in epithelioma.

Dr. M. L. Rhein, who has used all the strengths of Pyrozone, regards it as of great value, and he considers its lack of acidity as a very important factor in its employment.

Pyrozone solutions should not come in contact with organic matter, and hence a special Pyrozone Atomizer has been designed which is entirely of glass, except the rubber bulb, which can be detached in a moment, and the glass portion sterilized by boiling or otherwise. It is a very convenient and cleanly instrument.

Sanmetto in Dysmenorrhœa, Prostatitis, Gonorrhœa and all Vesical and Urethral Irritations.

I had a very satisfactory experience with Sanmetto. It has cured me of prostatitis. It is *par excellence* in dysmenorrhœa, prostatitis, gonorrhœa and all vesical and urethral irritations from any cause whatever. I speak whereof I do know. Sanmetto will please all experienced physicians. It is definite in results, and to the mind of the patient appreciable at once. Sanmetto has come to stay, and benefit the physician and his patients.

J. L. WAGLEY, M.D.,
Cleburne, Texas.

A Contribution to the Therapeutics of Trional.

BY DR. H. KOPPERS.

A study of the literature of Trional shows that it has proved itself an excellent sedative and hypnotic, and is everywhere commended for further trial. I will report a number of cases occurring partly in my own practice and partly in the private practice of Dr. Seifert, of Wurzburg.

In all these cases Trional was administered in the form of the powder, and it was found advantageous to dissolve it in warm water, milk, tea or bouillon, or to let the patient drink a cupful of either of these fluids after administration of the powder. In this form the remedy was readily taken and rejected in only two cases in which I resorted afterwards to its rectal application. To produce a hypnotic effect, a dose of one to two grammes was administered before retiring about 8 or 9 o'clock; while in cases where it was desired to arrest profuse perspiration, a single dose of 0.5 grammes usually sufficed. An increase of dose to two grammes failed to afford better results.

From the histories in these cases it will be seen that Trional possesses good anidrotic properties and is an excellent hypnotic. I would remark that the suggestion to utilize the remedy as an anidrotic came from Dr. Seifert.

That Trional possesses the power to arrest perspiration will not excite surprise when it is remembered that a very similar effect is exerted by its conginer, Sulfonal. In a dissertation by Schmidt, prepared under direction of Dr. Seifert, the anidrotic effect of Sulfonal is fully described. He employed Sulphonal mainly in phthisical cases, prescribing a single evening dose of 0.5 gramme, and in most cases obtained a complete cessation of the night sweats. As regards the manner of action of Sulfonal, he remarks that it must be of cerebral nature, since exanthenis have been repeatedly observed after administration of the remedy, an evidence that we are concerned here with a

paralysis of the vaso-motor center, or a paralysis of the cutaneous vaso-motor nerves derived from it. Although, in view of the small number of cases observed by me, I have not yet met with the exanthems after the use of Trional. It can scarcely be assumed that this remedy. like atropine or agaricine, exerts a direct paralysant effect upon the peripheral end-apparatus of the secretory nerves, but rather that it also should be regarded as having a cerebral effect (as demonstrated by Kast's experiments on animals) and probably a direct action upon the center for sweating in the medulla. The anidrosis produced by the small dose of 0.5 grammes. Trional was as marked as after the exhibition of drugs having a similar action, so that in this respect it is to be placed at the side of atropine or agaricine. Since restlessness at night and sleeplessness are often attended with increased perspiration, the employment of Trional for the purpose of obtaining a double effect, is perhaps preferable in these cases to other drugs. Over Sulfonal it possesses the advantage of producing very slight after-effects.

My observations regarding the above-mentioned action of Trional are not yet sufficiently numerous to warrant a positive decision, but at any rate the small number of favorable should encourage further investigations in this direction.

With reference to the hypnotic effect of Trional, I agree completely with Schultze, Schaefer, Botticher and others, but will subjoin a few remarks regarding its manner of employment, the development of its effects, the after-effects, its special influence upon the functions of certain organs, as well as regarding the points of comparison between the remedy and other hypnotics.

As is evident from the histories of the cases, in simple sleeplessness, agrypnia, nervosa, doses of one gramme Trional were usually sufficient to produce deep sleep, which continued all night. In conditions of more marked excitement, in psychical disease, an increase of dose to 1.5 or two grammes would seem to be indicated, as demonstrated by numerous reports from insane asylums and clinics for nervous diseases. According to my observations, an excess of dose over two grammes is scarcely ever necessary, because the development of a more perfect effect is not proportional to an increase of dose, and because after-effects are more likely to arise after administration of 2.5 to three grammes than after employment of a smaller quantity. I do not mean to say, however, that large doses will act injuriously upon the organism, which seems not to be the case, but in practice smaller doses are advisable as long as they afford the desired result.

In the case of patients who are unable to sleep on account of pains, the remedy — as also observed by Botticher — frequently leaves us in the lurch. Even in these cases, however, a certain effect can be demonstrated, the patients becoming more quiet and drowsy, although fails to occur if severe bodily pains are present. If they are not very pronouncd, an alleviation or even complete disappearance, followed by quiet and refreshing sleep, may take place. I would therefore agree with others that Trional acts chiefly as a hypnotic and has only slight anæsthetic effects.

Mention must also be made of the rectal administration of Trional. When employed in this manner, as shown in case 4, the effect, although somewhat delayed, was as intense as in the administration by mouth.

The hypnotic action usually occurred rapidly. While after the use Sulfonal considerable time, even several hours, frequently elapses before sleep ensues, the hypnotic effect of Trional was developed after fifteen minutes, and on the average within the course of half an hour. It is therefore advisable to take the remedy immediately before retiring, and to facilitate its action by giving it together with a small quantity of some warm fluid, such as milk, tea, water. Trional acts directly upon the cerebral cortical substance, which explains the sensations experienced by the patient, the feeling of weight in the head, the general lassitude and desire for rest, followed finally by that peculiar condition of brain exhaustion which is termed sleep. I frequently had an opportunity of observing that patients who, after

taking Trional, engaged in some little work about the room, suddenly broke off, and, in order to satisfy the desire for sleep, were compelled to seek the bed. In respect to this condition I coincide with Botticher's views, who, in opposition to Schultze, maintains that Trional is not to be considered as a remedy aiding in the production of sleep, but rather as a narcotic compelling sleep.

The action of Trional upon the brain is also concerned in the production of the after-effects which may occur after the patient wakes up, and consist of a feeling of pressure in the head, drowsiness, lassitude, marked sensitiveness toward noises and cutaneous hyperæsthesia.

The dull feeling in the head is usually localized to the anterior half of the cranium and both sides. It is not of the nature of a true cephalalgia; at least I have never encountered a case in which after administration of Trional the patient complained of pronounced pains in the head; and, on the contrary, have found repeatedly that where headaches were present they disappeared after the use of Trional and the resulting good sleep. All these appearances, however, are but slightly developed after doses of 1 to 1.5 grammes, and are readily recovered from by the patient. They disappear usually after a short time and frequently after taking breakfast. I have never observed more severe and disagreeable after-effects of this kind, such as tinnitus aurum, vertigo, staggering, vomiting, etc., which occur quite often after administration of Sulfonal.

changes in the respiration are not known to follow the use of Trional; the breathing was always normal and unimpaired, and the patients never complained of dyspnœa or other respiratory disturbances.

The same dose does not apply to the action of the remedy upon the heart and circulation.

The blood pressure is somewhat reduced by Trional, and the frequency of the pulse was repeatedly found increased by five to ten beats, and of course this is the more pronounced where there is cardiac lesion with or without disturbances of compensation. In the history of case 8, that of a person suffering from disease of the heart, the injurious influence of the remedy upon the heart action is distinctly shown, although a dose of only one gramme was employed. While it is true that others have not had this experience, I have become convinced on the ground of this case, however, that Trional exerts an injurious action in all cases where there are present cardiac lesions with disturbances of compensation; and I would therefore utter a note of warning against the use of Trional in these conditions, or at least advise a certain amount of caution.

No disturbances of the digestive organs were observed; the appetite remained unchanged, and nausea, vomiting, etc., were not seen by me. To determine whether the digestive mechanism of the stomach was altered in any manner by the ingestion of Trional, Botticher instituted several experiments in which, after the administration of the test breakfast, he gave two grammes of Trional and after fifty minutes withdrew the stomach contents. He found that neither a considerable increase or a noteworthy decrease of the acidity had taken place. I have made two experiments in the same manner, and am able to confirm Botticher's experience. In none of my cases were intestinal disturbances, such as diarrhœa, observed, while others report cases of diarrhœa following the use of Trional.

It remains to say a few words with regard to the effect of Trional when compared with other hypnotics. As regards its conginer, Sulfonal, I have in the foregoing remarks repeatedly contrasted the two substances. I often found that in cases where no sleep followed the administration of Sulfonal, Trional exerted an excellent effect. Aside from this, the latter is decidedly to be preferred to Sulfonal because of the more rapid, certain and prolonged action, and the far less marked complicating and after-effects. In comparison with chloralamide and amyl hydrate it produces a much more powerful and prompt action; the latter, which in the dose of three grammes has approximately the same effect

as two grammes of Trional, is not well borne on account of its disagreeable taste. Chloral hydrate or the bromides do not give the full effect of Trional. In cases, however, where an analgesic action is desired, it is unable to take the place of morphine.

In conclusion I would formulate the results of my experience with Trional as follows:

1. Trional is a very useful hypnotic which in doses of one to two grammes acts rapidly and positively in the most diverse cases.

2. It has been employed with especially good results in conditions of excitement in mental disease.

3. Occasionally after-effects, such as feeling of heaviness in the head, lassitude and drowsiness, occur, but these are not marked nor of long duration.

4. It is seldom necessary to exceed a single dose of two grammes, and not advisable because of the marked development of the after-effects.

5. Disturbances of the digestive organs very rarely, and disorders of the respiratory tract have never been observed.

6. In diseases of the heart, especially with disturbances of compensation, Trional is capable of evoking disagreeable and even injurious disturbances of the heart action, and should therefore be employed with caution in these cases.

7. Trional is a quite reliable anidrotic, single doses of 0.25 to 0.5 being sufficient to produce arrest of the perspiration.

Abstract from Helbing's Ph. Record, June, 1893, Number.

Dr. F. W. Passmore and myself have conducted a series of examinations on Cocaine Preparations.

The accruing advantages obtained from systematic investigation of these bases are readily recognized. There is hardly any alkaloid compound which is found in commerce in more varying degrees of purity than Cocaine, and none which is more important to obtain pure.

It gives me pleasure to place on record the fact that the Cocaine preparations and especially the Hydrochlorate of Cocaine of C. F. Boehringer & Soehne have been found free from all impurities. They answer all the tests of the Pharmacopœias and yield definite, unvarying physiological action without secondary effects.

It can only be by patient investigation, vigilantly pursued, that this manufactory has attained the high standard of purity reached by the preparations we have reported upon.

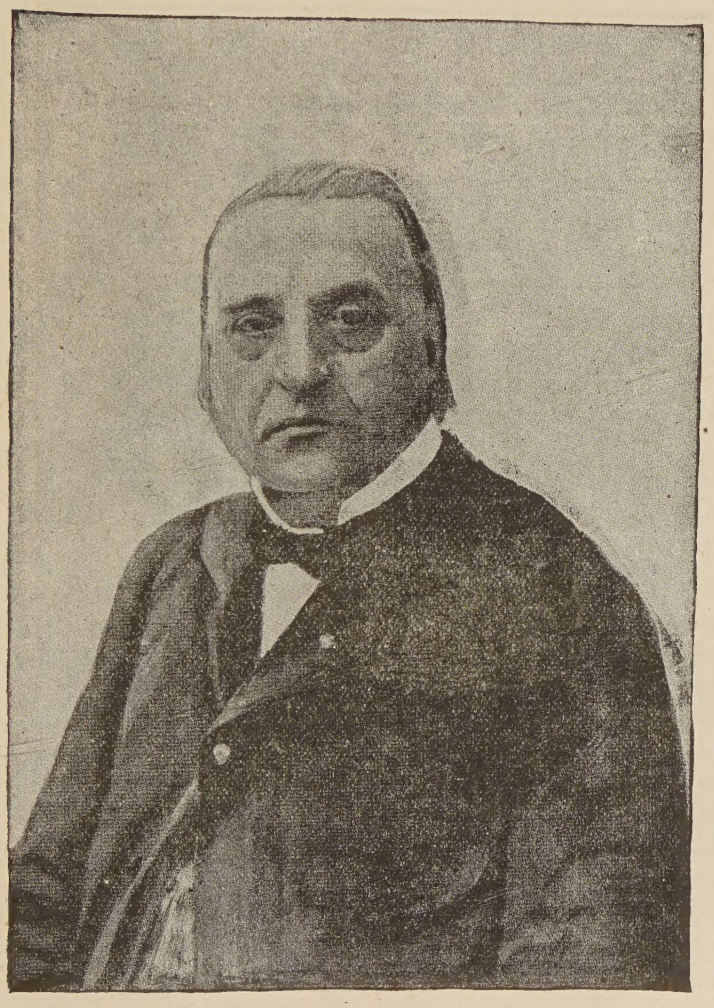
H. HELBING, F.C.S.,
Analytical and Consulting Chemist,
63 Queen Victoria St., London, E. C.

The Treatment of Cataract with Succus Cinerariæ Maritimæ.

Dr. E. B. Wenner (*Times and Register*, April 15, '93) reports a case of cataract causing total blindness in an aged person, with very encouraging results at time of writing. Two drops were instilled into the eye three times daily. About two weeks after commencement of this treatment the patient began to notice the difference between light and darkness; one week later she could distinguish the hand when placed between her eyes and the window. At present she is able to distinguish the movements of the fingers before her eyes. The doctor is still continuing the treatment with hopes of entirely removing the opacity.

Acute Muscular Gout.

Mr. A. B. complains of severe pain in the thigh, extending down into the popliteal space. The pain involved the satorius and and the abductor muscles of the the thigh. As he had gouty inflammation of the joints, I diagnosed his case as "muscular gout" and prescribed Henry's Tri-Iodides. Cured in a few days.



PROFESSOR J. M. CHARCOT (from the Lancet).

PROFESSOR J. M. CHARCOT (from La Nature).

Professor Charcot.

Jean Martin Charcot, the news of whose unexpected death last week caused a shock to the whole medical profession, was born in Paris, November 29, 1825. He was the son of a carriage builder. He studied medicine in the Paris faculty under Piorry, Claude Bernard and others, taking his doctor's degree in 1853. In 1856 he won, by competitive examination, the post of physician to the Bureau Central, the general sorting house, as it may be called, of the Paris hospitals. In 1860 he became *Professeur Agrege*, and two years later he was appointed physician to the Salpetriere, at that time simply a house of refuge for infirm and weakminded old women. In 1883 he was appointed professor of pathological anatomy in the Paris Medical Faculty in succession to Cruveilhier, and in 1880 a special chair of clinical neurology was created expressly for him. He continued to lecture almost till the day of his death. In 1873 he was elected a member of the Academy of Medicine, attaining the supreme honor of membership of the Institute of France in 1883.

Early in life M. Charcot was rescued by marriage from that struggle for existence in which the eager flame of scientific ambition must so often be spent in making the domestic pot boil. Thus he was free to devote himself to the advancement of medical science, and in the Salpetriere, with its 4,000 beds, he found a quarry of clinical material out of which he was able to raise an edifice of intellectual achievement, at once solid in structure and artistic in finish, which will form a *monumentum ære perennius* to his memory. He set aside three days in the week entirely for hospital work, and he was always most punctual in his attendance. By his influence the Salpetriere was transformed from something corresponding to a poor-law asylum into a great clinical school, fully equipped for research as well as for teaching, and open to the whole profession.

Though limiting his time for private practice to the extent that has been mentioned, M. Charcot was consulted by patients from the very end of the earth. He seldom undertook the treatment of sufferers, preferring to act purely as a consultant. So far did he carry this mode of action that, we believe, he seldom prescribed, contenting himself with pointing out the clinical and pathological relations of the case and indicating the general principles on which the treatment should be conducted, leaving the practitioner in charge to apply them according to his lights.

He was passionately fond of art, and he had a highly-cultivated æsthetic sense; he was also skillful with his pencil and illustrated his demonstrations with sketches of considerable power. His house in the Boulevard St. Germain was a museum of artistic treasures, collected by himself with rare taste and judgment. His intellectual tastes were by no means limited to the field of medicine; he took a keen interest in natural history and was well versed in archæology. He was happy in his home life, and his only son is now qualifying himself to follow in his father's footsteps by going through the invaluable scientific discipline of the *internat* (house physicianship) at the Salpetriere.

Among M. Marcot's most important works may be mentioned his *Lecons sur les Maladies du Foie*, and his *Lecons sur les Maladies Chroniques et des Vieillards*, an English translation of which was published by the New Sydenham Society in 1881; his *Lectures on the Localization of Cerebral and Spinal Diseases*, published under this English title by the same society in 1883; his famous *Lecons Cliniques sur les Maladies du Systeme Nerveux*, also translated for the New Sydenham Society (3 vols., 1887-89); and his *Lecons du Mardi a la Salpetriere*. A complete edition of his works was published in 1886. In 1880 Charcot founded the *Archives de Neurologie*, which he continued to edit till his death; he also took a leading part in editing the *Revue de Medecine*, the *Archives de Pathologie Experimentale*, and that wonderful album of hysteria and latter-day demonology, the *Nouvelle Iconographie de la Salpetriere*.

In person M. Charcot bore a striking resemblance to the first Napoleon. He had for some time been in failing health, and about a fortnight before his death fainted while delivering a lecture. Nothing serious, however, seems to have been suspected by himself or by those about him, and he looked forward with confident anticipation of benefit from a short rest. He accordingly started on an archæological expedition to Morovan in company with Drs. Debove and Straus.

After a pleasant day, during which M. Charcot seemed to enjoy himself thoroughly, and delighted his companions with conversation at once sparkling and profound, the party stopped at a little inn at Settons, near Chateau Chinon. Plans were formed for the next day, but in the morning M. Charcot was found dead in his room with a half-finished letter to his son on his desk. The last words he had written being: "I hope to finish to-morrow, as we must rise before six. I must now try to sleep." The cause of death appears to have been angina pectoris.—*British Medical Journal.*

DIAGNOSIS AND TREATMENT OF DISEASES OF THE EAR, NOSE AND THROAT, by Eminent American, British, Canadian and Spanish Authors. Edited by Charles H. Burnett, A.M., M.D., Emeritus Professor in the Philadelphia Polyclinic and College for Graduates in Medicine; Clinical Professor of Otology in the Woman's Medical College of Pennsylvania; Aurist to the Presbyterian Hospital, Philadelphia. Illustrated. Complete in two imperial octavo volumes of about 800 pages each. Price per volume: Cloth, $6.00; full sheep, $7.00; half Russia, $7.50. J. B. LIPPINCOTT Co., Publishers, Philadelphia, Pa., U. S. A.

The first volume of this treatise gives us an idea of the scope of the work the author has undertaken. The first volume is devoted mostly to the consideration of the ear and its diseases. Made up, as it is, from the contributions of the best writers on the various diseases considered, it must hold a high place in the standard literature of the day. It is systematic, concise and accurate in description. It is what the general practitioner needs for help and guidance in the cases he is compelled to treat. It is what the specialist wants for daily consultation.

The author has appreciated the necessities of the times in combining in a single treatise the diseases of these organs which are so closely related, anatomically and physiologically, the ear, nose and throat.

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